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ABSTRACT

Effective rehabilitation requires the counselor to serve as his client's advocate. The goals of rehabilitation are clear and are product oriented. While skill as a counselor is required to achieve these goals for many clients, the clients represent problems which will require more than counseling skills before the problems can be resolved and the goals of rehabilitation achieved. The counselor can not leave the problems of social intervention on the part of clients up to others while he serves either as therapist or community coordinator. He must act in partnership with his client and demonstrate to his client that he is truly acting as his advocate before a partnership can be achieved which will lead to rehabilitation. (KJ)

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THE REHABILITATION COUNSELOR AS CLIENT ADVOCATE

J. Blair Stone

Introduction

The issue, "What is a rehabilitation counselor?" has been with us so long and so much has been written and said concerning the issue that most of us who have been in the field for awhile are thoroughly tired of the debate. And yet the issue will not die. The reason, of course, is fairly obvious. Individuals engaged in the work of rehabilitation counseling are suffering from an identity crisis. They see themselves doing very significant work; work which they believe should be accorded professional status but common agreement as to the nature of the profession cannot be reached.

While there are many issues on which disagreement exists in regard to the profession of rehabilitation counseling, the major issue has always been the rehabilitation counselor as a <u>therapist</u> and the rehabilitation counselor as a <u>facilitator</u> and <u>coordinator</u> of services. Those who see the rehabilitation counselor as therapist deny any difference in function between rehabilitation counseling and counseling in any other setting. They further deny any significant difference between counseling and psychotherapy. From this position the profession of rehabilitation counseling is quite clear. The rehabilitation counselor is a professional therapist who provides psychotherapy for those clients who have serious problems of personal adjustment. It is acknowledged that many clients of rehabilitation do not represent problems of personal adjustment so serious as to require long term, in depth psychotherapy. Such clients will need services to become rehabilitated but those services can be provided by personnel at a "subprofessional" level leaving the counselor to deal only with those cases who require his skills as a psychotherapist.

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Those who see the rehabilitation counselor as a facilitator and coordinator of services view case management as the primary role of the professional in rehabilitation. The counselor's job is to move cases as rapidly and effectively as possible from a referred to a closed status. The counselor accomplishes this by purchasing and coordinating services in the community designed to meet the needs of his clients, including psychotherapy where indicated. This approach to rehabilitation counseling emphasizes knowledge of community resources and coordination of such resources along with effective case reporting as the primary professional skills required in rehabilitation counseling. While this approach to rehabilitation counseling may also make use of sub-professional personnel, their role in the rehabilitation process is less clear but is most frequently discussed in terms of routine clerical tasks.

The two opposing points of view I have sketched in regard to the profession of rehabilitation counseling represent extremes and most of us would not completely identify with either point of view. This is partly due to uncertainty and insecurity regarding our professional role and hence a tendency to temporize on such issues, but it is also due to manifest weaknesses in both points of view.

As I said at the beginning of this talk, all of us are tired of the question "What is a rehabilitation counselor?" Despite this fatigue and the abundance of material on the topic I am about to add my conceptions to this overworked field. I feel free to do so because, like all college professors, I am convinced I have the final word on the issue. If it turns out that I am wrong, so much the better since then the issue will not die and my colleagues and I can continue to give the speeches and write the papers which hopefully will lead to our promotions.

My position in regard to rehabilitation counseling is somewhere between the two extremes I have already sketched. In my view rehabilitation counseling is basically a counseling profession and thus the usual concepts of considering the whole individual and developing an effective counseling relationship are relevant. However, it is further my position that the goals of rehabilitation and the nature of clients served through rehabilitation are such as to require active intervention by the counselor in the society to which his client must relate if rehabilitation is to be successful. My model might be termed "The rehabilitation counselor as client advocate".

Goals

While state rehabilitation agencies are gradually moving to a liberal interpretation of the term "rehabilitation", vocational adjustment remains the primary goal of such agencies. Although we may change some of our definitions of what constitutes vocational adjustment, I believe it will continue to be the most significant goal of programs of rehabilitation in the years to come. Where vocational adjustment is not the primary goal of rehabilitation, a return to some higher level of functioning within society is, by definition, the goal of efforts at rehabilitation. Thus, our efforts are currently and will likely continue to be product oriented. What McGowan and Porter (1964) have said of employment counseling is equally true of rehabilitation counseling. Counselors in rehabilitation settings are, of necessity, "more concerned with the tangible or product aspects of counseling outcome than with reconstructing the emotive or process aspects of a counselee's personality".

Although our goals are product oriented, we have learned that these goals cannot be reached without some concern with the process aspects of counseling. Adjustment to society, including vocational adjustment, is

dependent upon the total personality functioning of the individual. The old trait-factor approach to counseling which emphasized information plus "pure reasoning" has been found to be inadequate particularly when dealing with populations like the disabled where adjustment to society is inextricably interwoven with problems of personal adjustment. We find we must concern ourselves not only with such traits as aptitudes and interests but also with such variables as feelings, attitudes and aspirations. With this view of counseling, motivation and self-perception carry equal weight with aptitude and other "traits".

If rehabilitation counselors have learned that the total personality functioning of their clients must be considered to effectively achieve their goals; they have likewise learned that much attention must be directed to the nature of the counseling relationship in order to maintain effective communication with their clients. There appears to be general agreement that a counseling relationship characterized by mutual trust, acceptance, and understanding is most likely to result in the effective and open communication so necessary to the achievement of counseling goals including the goal of adjustment to society.

Thus the goal of rehabilitation counseling is rather clear cut. It is adjustment to society including especially vocational adjustment. In order to achieve this goal counselors emphasize the product aspects of counseling more than the process aspects of counseling. They must also, however, recognize the totality of personality functioning and must develop skill in the process aspects of counseling, particularly those process aspects concerned with establishing an effective counseling relationship.

Unfortunately, in most cases, the goal of adjustment to society cannot be realized through counseling alone as we typically define counseling. It requires that the counselor become an advocate for his client to the larger

society of which his client must become a part if the goal of rehabilitation is to be achieved. The reson this is so often the case in rehabilitation counseling is due not only to the product oriented nature of our goals but to the nature of clients served as well. This will become increasingly true as the nature of our clientele begins to change.

Clients

Currently the mentally and physically disabled constitute the bulk of clients served by rehabilitation agencies. While such individuals will continue to represent a very significant proportion of our clients in the future, the 1968 Amendments to the Vocational Rehabilitation Act make it clear that the socially and economically disadvantaged are soon to represent a major portion of our clientele. The mentally and physically disabled represent certain problems which, in my opinion, require the counselor to act as an advocate as well as a counselor. The disadvantaged represent essentially these same problems but differ in the intensity of the problems. This difference in intensity will require an even stronger commitment to client advocacy on the part of rehabilitation counselors than is currently the case. Briefly, the problems which I believe require the counselor to act as advocate are as follows: (1) Both the disabled and the disadvantaged have expectations regarding counseling which affect the counselor's role.

(2) Neither the disabled nor the disadvantaged represent the "norm".

(3) Both the disabled and the disadvantaged are victims of prejudice.

(1) Both the disabled and the disadvantaged have expectations regarding counseling which will affect the counselor's role.

As I have pointed out in a previous article (Stone, 1966) there is a rather clear-cut expectation on the part of most disabled clients that their counselors will provide specific services leading to the amelioration

of the client's disability or to placement on a job or to both. Disabled clients tend to focus so much on their disability and the limitations it imposes on their ability to function normally in society, especially in regard to obtaining and keeping a job, that all of their energies are directed to this problem. Under these conditions, any attempt by the counselor to focus on concerns not perceived by the client as directly related to his disability or his need for employment is frequently taken as a threat to his goals rather than assistance in achieving them and arouses anxiety on the part of the client. The expectations disabled clients have regarding the nature of services to be obtained through rehabilitation counseling, and the anxiety which is produced when the counselor attempts to discuss matters not perceived by the client as directly related to those expectations, frequently make it very difficult for the counselor to deal with problems of personality or adjustment. In other words, no matter how convinced the counselor is that counseling should involve the total personality in order to effectively achieve the goal of vocational adjustment, he is frequently forced to provide services perceived by the client as directly related to his needs before counseling can proceed. Any attempt to do otherwise may arouse anxiety and endanger the counseling relationship.

Disadvantaged clients, like disabled clients, also have rather definite needs leading to definite expectations in regard to what successful services will provide them. These needs may be related to money, the need for a car, or new clothes. These needs may seem rather superficial to us but not to the client. Indeed, many disadvantaged persons take a very dim view of all public agencies because in their experience such agencies have failed to meet their needs and resultant expectations. Given this situation, the rehabilitation counselor working with the disadvantaged has the same

problem he has in working with the disabled except it is likely to be even more intense. The counselor must provide services directly perceived by the client as meeting his expectations or anxiety and, especially with the disadvantaged, hostility may result. Too much anxiety and/or hostility may act to disrupt the counseling relationship. In working with the disabled and especially in working with the disadvantaged, rehabilitation counselors must frequently intervene in society in such a way as to meet the client's felt needs and resultant expectations before a counseling relationship can be developed based on mutual trust and understanding. In other words, the counselor must prove his advocacy for the client's cause before an effective counseling relationship can be developed.

(2) Neither the disabled nor the disadvantaged represent the "norm".

While the concept of normality is at best very poorly understood, both the disabled and the disadvantaged represent variances from the mainstream of American culture and in this sense do not represent the norm. Since they do not represent the norm of society they frequently require services beyond the competencies of their counselors to provide. In the case of both the disabled and the disadvantaged; medical, educational, social and technical services are frequently required in addition to counseling if successful rehabilitation is to be achieved. This requires that rehabilitation counselors become expert at community referral and community coordination, sharing their client with other professionals while still maintaining primary responsibility for him. It also requires the counselor become an active promoter of facilities and resources in his community which are needed to achieve the rehabilitation of his clients. Such promotion is simply another instance of counselor advocacy in the service of his clients.

The problem of norms also exists in regard to the use of normative data of the kind provided by tests and questionnaires. Such data is commonly regarded as an essential part of counseling, particularly counseling aimed at vocational adjustment. The rehabilitation counselor is interested in determining how well his client may compete in society. Thus he relies frequently on tests, questionnaires and the like to provide him with information which will assist in predicting success for his client in society. In many cases the prediction is disappointing. Such information is, of course, of value to the rehabilitation counselor but it tells him little about his client's basic potential because, as others have pointed out, we cannot rely on normative data for understanding our clients when our clients do not represent the norm on which the data is based. This is currently a serious problem when working with the disabled. It will become a much more serious problem as we begin to work with the disadvantaged where variance from the norm group on which a test or questionnaire is based is even greater than is true for most disabled individuals.

Serious as norms and normality are in relationship to community resources and the problem of tests, their major consequence to the disabled or disadvantaged client, and thus to the client's counselor, is the pervasive lack of acceptance with which persons are faced who do not fit the norm of American society.

(3) Both the disabled and the disadvantaged are victims of prejudice.

That the disadvantaged, particularly minority group members, suffer from prejudice is a well documented, and in general, well accepted fact. That the disabled are also victims of prejudice is probably less well recognized by the general public. The nature of prejudice and the causes of prejudice against the disabled are discussed very well in a classic article by Gellman entitled "Roots of Prejudice Against the Handicapped"

(1959). It is an article well known to most of you I suppose and his discussion will not be elaborated upon here. Suffice it to say that the disabled are victims of prejudice for essentially the same reason as the disadvantaged; they do not represent the norm of society. Like the disadvantaged, the disabled suffer most not from the obvious prejudice of the outspoken bigot, but from the subtle prejudice of individuals of good will who, through ignorance and lack of awareness, are not conscious of their prejudice. Also like the disadvantaged, the disabled suffer from a monolithic form of institutional prejudice which is very difficult to combat in an increasingly complex and rigid society.

The problems of prejudice are undoubtedly more severe in regard to the disadvantaged than they are in regard to the disabled. Nevertheless, due to their long experience with problems of prejudice against the disabled, rehabilitation counselors should be well prepared to deal with prejudice against the disadvantaged. It might be instructive to review examples of how rehabilitation counselors have dealt with prejudice against the disabled for the suggestions they might provide for dealing with prejudice against the disadvantaged.

Perhaps the most subtle and difficult to combat form of prejudice with which counselors of the disabled or disadvantaged have to deal is the tendency toward stereotyping of individuals in our society who do not fit the norm. In programs where the goal is vocational adjustment, this becomes an especially critical problem in regard to employers and employment. Rehabilitation counselors have found that most employers express no open hostility toward the disabled. In fact, employers are frequently solicitous and speak of the disabled as needing the help and support of society. They may even point with pride to one or more disabled workers currently on their payroll. One gets the feeling that the disabled workers have been employed

as a showpiece in much the same way that some employers brag of a Black on the work force. However, such employers most often continue to say that unfortunately they do not currently have any job available which a disabled person could be expected to perform. The employer is, of course, unaware of his prejudice but what he is revealing in such comments is a stereotyping of all disabled persons as individuals who need the help of society but who cannot be expected to perform in competitive employment. He refuses to see the disabled person as an individual whose disability may or may not relate to any specific job. Rehabilitation counselors have recognized that the goals of vocational adjustment cannot be met so long as employers possess attitudes of prejudice. Thus, much of the rehabilitation counselor's work has frequently involved changing employer attitudes toward the disabled client. Such work has had a gradual but significant impact upon employer attitudes toward disability in general.

If stereotyping has been a problem with the disabled, rehabilitation counselors will find it to be an even greater problem with the disadvantaged. The rehabilitation counselor working with disadvantaged clients will quickly learn that the goals of rehabilitation with such clients cannot be reached until attitudes of significant members of society are changed and until disadvantaged persons are viewed as individuals rather than as members of a highly stereotyped group. Success in changing employer attitudes toward the disabled has been achieved to a striking degree over the years, although we still have far to go. Success has been largely achieved through the quiet advocacy of rehabilitation counselors on the part of their disabled clients. The same kind of advocacy will be needed to an even greater degree with the disadvantaged.

Institutional prejudice is almost as formidable a barrier to successful

rehabilitation as employer prejudice. Such items as unreasonable physical, mental or educational requirements for employment or training have foiled many a well thought out and otherwise reasonable plan for the rehabilitation of a disabled client. Problems of institutional prejudice are very hard to deal with because of the difficulty in pinpointing responsibility for such prejudice. However, one problem of institutional prejudice which is being effectively combatted in regard to the disabled may prove instructive. Many rehabilitation counselors have had the experience of working out meaningful and effective plans for rehabilitation with their clients only to discover that the employment or training setting involved in the plans have architectural barriers which make it impossible for their client to get to the employment or training site. Increasingly frustrated by such problems, rehabilitation workers as well as members of disabled groups themselves have managed to exert enough pressure through their professional and special interest groups to begin to solve the problem of architectural barriers. Some state legislatures have passed laws requiring all public buildings in their states to remove architectural barriers to the disabled and professional organizations of architects are beginning to consider the problem of architectural barriers in their designs for private buildings. Here is a clear case of client advocacy and social intervention on the part of rehabilitation counselors in partnership with their clients to change one area at least of institutional prejudice.

Social intervention is required to change institutional prejudice. We have learned that such intervention in the service of disabled clients can bear significant fruit. Such intervention will be required to a much greater degree with the disadvantaged if we are to be successful in our efforts at rehabilitation with these clients. We cannot sit back as professionals in rehabilitation and expect others to take the lead in

removing institutional prejudice because it is we, along with our clients, who know where the problems are; such things as educational requirements in business and industry where such requirements bear little or no relationship to the nature of the jobs being performed, admission requirements of training institutions which make it impossible for those who need training most to obtain it.

In summary, if the rehabilitation counselor is to be effective in achieving the goals of rehabilitation with his disabled clients and particularly with disadvantaged clients whom we are gradually beginning to serve, he must devote much of his time and effort at client advocacy as well as more typical counseling endeavors. It may do little good to develop an effective counseling relationship, to attempt to foster self-acceptance, self-understanding, and positive self-regard for a client if he must exist in a society which continually demonstrates to that client he is a second rate citizen. At the practical level, the major goals of rehabilitation counseling will often not be achieved unless subtle forms of individual prejudice and monolithic forms of institutional prejudice are removed. The rehabilitation counselor must demonstrate to individual employers and training agencies that his clients are individuals, not simply members of a highly stereotyped group. He must actively band together with his clients to change institutions and eliminate institutional prejudice which denies to the client the opportunity for true vocational as well as personal adjustment.

Summary

What I have attempted to indicate with this presentation is my belief that effective rehabilitation requires the counselor to serve as his client's advocate. The goals of rehabilitation are clear and are product oriented.

While skill as a counselor is required to achieve these goals for many clients; the clients represent problems which will require more than counseling before the problems can be resolved and the goals of rehabilitation achieved. I do not believe the counselor can leave the problems of social intervention on the part of clients up to others while he serves either as therapist or community coordinator but must act in partnership with his client and demonstrate to his client that he is truely acting as his advocate before a partnership can be achieved which will lead to rehabilitation.